NATIONAL INSTITUTES OF HEALTH
WARREN GRANT MAGNUSON CLINICAL CENTER
NURSING DEPARTMENT

Standard of Practice: **Care of Patients Undergoing Endoscopic Procedures**

Background Information

- Assessments, interventions, and documentation actions listed in this SOP apply to nursing staff from the Endoscopy Area as well as the patient care units. Actions to be completed by the Endoscopy nursing staff will be preceded by an asterisk (*).
- Utilize the sedation worksheet and guidelines from the CC Medical Administration Policy on Administration of Sedation M92-9

I. **PRE PROCEDURE**:

A. **Assessment**

1. Review lab values (example: CBC, coagulation, electrolytes), allergies, diagnosis, vital signs, weight, age, current medications and notify physician of abnormalities.
2. Review history for any underlying medical/surgical problems and issues with previous procedures, which may increase risk of procedure (example: asthma, malignant hyperthermia, TB or other infectious disease, previous MI, and valve disease).
3. Verify patient NPO according to medical order and ASA NPO guidelines described in the CC policy for Administration of Sedation
4. Verify that arrangements have been made for a responsible adult to accompany outpatients upon discharge.
5. Obtain baseline T, BP, P, R, weight, and oxygen saturation prior to sending patient to procedure
6. * Review chart for informed consent obtained prior to administration of sedation medications
7. * Immediately prior to procedure, verify that the pre-procedure assessments on the sedation worksheet are completed: (Conscious sedation provider completes ASA physical status scale, airway evaluation, current medications, pertinent medical & surgical history, and physical examination. Nurse completes remainder of pre-procedure assessment section).
8. Verify that emergency medications and antagonists (e.g. Narcan and Flumazenil) are readily available in the area where patient will receive treatment.

B. **Intervention**

1. Instruct patient/caregiver regarding procedure.
2. Instruct patient regarding preparation for test.
3. Instruct outpatients regarding need for a responsible adult to take patients home after conscious sedation.
4. Establish IV access if patient is to undergo conscious sedation. Check with Endoscopy staff to determine if sedation is planned.
5. * Set up appropriate scope and test functioning (refer to Manual of Gastrointestinal Procedures).
6. * Set up and verify function of needed equipment as indicated for procedure
   a. Bicap
   b. EKG monitor
   c. bag ventilator mask unit

6. Ensure emergency equipment is available in patient's room:
   a. Normal saline flush solution
   b. Oxygen
   c. Suction machine
   d. Vital sign monitor
   e. Crash cart

II. INTRA PROCEDURE (BY * ENDOSCOPY STAFF)

A. Assessment

1. * Vital Signs: BP, P, R, oxygen saturation q 5 minutes.
2. * Level of consciousness q 5 minutes.
3. * Patient's tolerance of procedure and anxiety level q 5 minutes.
4. Patency of IV site(s)

B. Interventions

1. * Explain procedure(s) to patient/caregiver.
2. * Remain with patient and provide verbal and tactile reassurance during entire procedure.
3. * Spray throat with topical anesthetic as ordered if patient is having an upper endoscopy.
4. * Assist patient into appropriate position for procedure (refer to Manual of Gastrointestinal Procedures).
5. * Administer medication for conscious sedation as ordered by credentialed conscious sedation provider.
6. * Assist physician with biopsies, brushings, aspirations, polypectomy, sclerotherapy, gastrostomy tube insertion (refer to Manual of Gastrointestinal Procedures).

III. POST PROCEDURE

A. Assessment

1. * Vital signs, LOC, and pulse oximetry q 5 minutes.
2. *Ability to move extremities
3. * Continuous pulse oximetry and visual observation during transport.
4. Continuous pulse oximetry and visual observation while recovering. (Note: refer to CC policy: Administration of Sedation)
5. VS after transfer to the unit (inpatients or outpatients) q 15 minutes until respirations return to baseline and pulse oximetry at 94 % or at baseline and BP and pulse within 20 % of baseline.
6. Patient response to procedure (example: nausea, bloating, and anxiety).
7. Signs/symptoms of complications, i.e., bleeding, pain, nausea, and vomiting (monitor until controlled).
8. Complete the post-procedure section of the sedation worksheet: assessing activity, the respiratory system, circulation, level of consciousness, and oxygen saturation.
9. Voluntary cough, ability to swallow, gag reflex and move extremities returned to baseline.

*Indicates duties to be performed by the Endoscopy Staff.

B. Interventions

1. * Transfer patient when stable via w/c or stretcher and give report to receiving RN.
2. * Send specimens to appropriate lab.
3. * Instruct Unit Nurse and patient about remaining fasting for 1 hour post procedure.
4. Assure patient safety while under effects of sedation by having side rails up and bed in low position and locked.
5. Maintain IV access for patients requiring hydration and/or vital signs and level of consciousness return to baseline.
6. Provide test swallow of water after NPO period when patient alert and voluntary cough, swallow and gag reflex return.
7. Discontinue post-procedure monitoring when the following parameters return to baseline: patient has a DC score of ≥ 9 for inpatients or ≥ 10 for outpatients: (See sedation worksheet)
8. Provide diet once cough, gag, and swallow reflexes are intact and any vomiting has resolved.
9. Discharge outpatients when:
    a. Patient seen by a physician or practitioner.
    b. A responsible adult demonstrates knowledge of "post operative instructions" (see sedation worksheet)

IV. DOCUMENTATION

1. * Type of Endoscopic procedure performed and any other interventions (example: biopsies and dilatation).
2. Patient response to procedure and any interventions on the sedation worksheet.
3. Vital signs, pulse oximetry, and LOC as above.
4. Oxygen given.
5. Medications and IV fluids given.
6. Voluntary cough, ability to swallow, gag reflex and move extremities returned to baseline.
7. Assessment and interventions as above.
8. Patient teaching, learning, and discharge instructions.

REFERENCES:

1. Schaffner, M. (ED) (1994). Manual of Gastrointestinal Procedures. 3rd Ed. Society of Gastroenterology Nurses and Associates. Williams and Wilkins.
2. CC Medical Administrative Series #M92-9 (rev.21 June, 2000) Policy: Administration of Sedation
3. Gastroenterology Nursing A Core Curriculum (1993) Society of Gastroenterology Nurses and Associates, Mosby Year Book: St. Louis Patient Teaching Plan: Endoscopic Procedure: ERCP
4. Patient Teaching Plan: Gastroscopy

Approved:

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Chief, Nursing and Patient Care Services

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